CHAPTER 7

Disenrollments

It will be necessary to disenroll individuals from the Community Supports Waiver for various reasons. Regardless of the reason for disenrollment, the **Notice of Disenrollment (Community Supports Form 17**) must be completed. **Within two (2) working days,** you must update the budget to reflect actual units used prior to disenrollment, inactivate the budget via BDINA on the Waiver Tracking System using the disenrollment date as the budget end date, and complete the **Notice of Disenrollment (Community Supports Form 17)** entering the basic identifying information and checking the box that corresponds with the reason for disenrollment. The **Notice of Disenrollment (Community Supports Form 17) must be reviewed by a Supervisor and signed by a Supervisor.** Once completed, the original, including Reconsideration and Appeals Procedure on the reverse side/attached, must be sent to the individual or his/her legal guardian. Copies of the **Community Supports Form 17** must be sent to the Regional DHHS Medicaid Eligibility Worker and to the Waiver Enrollments Coordinator (see Attachments 2 and 3, Chapter 6) along with one being maintained in the individual's file.

Medicaid policy requires that Community Supports Waiver individuals be given written notice regarding Community Supports Waiver disenrollment and a ten (10) calendar day waiting period, for allowance of appeal/reconsideration, before proceeding with the disenrollment, except in the conditions noted below. The following reasons do not require a ten (10) day notice before proceeding with disenrollment:

- Loss of Medicaid eligibility,
- Death,
- Individual moves out of state,
- Individual is admitted to an ICF/MR or NF,
- Individual is admitted to a Nursing Facility,
- Individual has been in a hospital/nursing facility/jail in excess of thirty (30) consecutive days
- Individual enrolls into another HCB waiver (i.e. MR/RD)
- Individual cost limit has been reached.

When completing the **Notice of Disenrollment (Community Supports Form 17)**, you must note the reason for the disenrollment. Disenrollment may occur for one of the following reasons:

- **Individual dies**. The Community Supports Waiver effective date of disenrollment will be the day the individual died.

- **Individual is no longer eligible for Medicaid as determined by SCDHHS/Eligibility**. The Community Supports Waiver effective date of disenrollment will be the day before the individual became Medicaid ineligible.

- **Individual has not received service(s) since enrollment**. The Community Supports Waiver effective date of disenrollment will be forty (40) calendar days from the individual's enrollment date or if the form is being completed late, the Community Supports Waiver effective date of disenrollment will be ten (10) calendar days from the date that the **Notice of Disenrollment (Community Supports Form 17)** is completed.

- **Individual was <u>admitted</u> to an ICF/MR**. The Community Supports Waiver effective date of disenrollment will be the day before he/she was admitted to the facility.

- **Individual was <u>admitted</u> to a Nursing Facility**. The Community Supports Waiver effective date of disenrollment will be the day before he/she was admitted to the facility.

- **If an individual is enrolling in another HCB waiver,** he/she must disenroll from the Community Supports Waiver first. You will complete the **Notice of Disenrollment (Community Supports Form 17).**

  <u>Note:</u> To avoid a break in service, the Waiver Enrollments Coordinator will verify with you when the individual is ready to disenroll from the CSW and enroll into the selected waiver. Negotiate an acceptable enrollment date to allow for proper completion of all enrollment requirements.

  Fax the **Notice of Disenrollment (Community Supports Form 17)** to the Waiver Enrollments Coordinator and send a copy to the District I Waiver Coordinator as well. A copy should also be provided to the recipient and the original placed in the recipient's file. Once disenrollment is complete, enrollment into the selected HCB waiver can begin.

  <u>Note:</u> The new waiver enrollment date will be the day after termination from the CSW to ensure there is no break in service.

- **If the individual is voluntarily withdrawing or no longer wishes to receive services funded by the waiver**, the **Notice of Disenrollment (Community Supports Form 17)** and the **Voluntary Termination Statement (Community Supports Form 19)** must be completed. A copy of the **Voluntary Termination Statement** must be submitted to the District I Waiver Coordinator when the **Notice of Disenrollment (Community Supports Form 17)** is sent to the Waiver Enrollments Coordinator. A copy should be provided to the individual and the original placed in the individual's file. The Community Supports Waiver effective date of disenrollment will be ten (10) calendar days from the date the individual notifies you that he/she wishes to voluntary withdraw from the Community Supports Waiver.

- **Individual no longer meets ICF/MR Level of Care** (See Chapter 5 for information about ICF/MR LOC). The Community Supports Waiver effective date of disenrollment will be ten (10) calendar days after the date the individual was found to no longer meet ICF/MR Level of Care.

- **Individual moved out of state**. The Community Supports Waiver effective date of disenrollment will be the date you were notified that the individual moved out of state and is no longer receiving services.

- **No service(s) received in thirty (30) calendar days**. This means the individual is not **<u>receiving</u>** services funded through the waiver and has not received a service for thirty (30) calendar days. In the space given, indicate the service or services not received in thirty (30) calendar days and the last date that services were received. The Community Supports Waiver effective date of disenrollment will be forty (40) calendar days following the individual's last date of service or if the form is being completed late, the Community Supports Waiver effective date of disenrollment will be ten (10) calendar days from the date that the **Notice of Disenrollment (Community Supports Form 17)** is completed. If the individual is able to resume services prior to the tenth (10^{th}) day, the disenrollment can be disregarded and the individual can remain enrolled in the Community Supports Waiver. However, you must notify the Waiver Enrollments Coordinator in writing via e-mail or by telephone that the individual has received a service prior to the tenth (10^{th}) day and that the disenrollment can be disregarded. You must

receive verification from the Waiver Enrollments Coordinator to ensure that the **Notice of Disenrollment (Community Supports Form 17)** has not been processed.

- **The individual has reached the individual cost limit**. The effective date of disenrollment will be the last date services were received.

The following three special exceptions apply to disenrollment and allow an individual to disenroll from the Waiver, but retain their Waiver slot for up to ninety (90) calendar days:

1. **An individual's Medicaid eligibility has been interrupted**, but Medicaid eligibility should be reinstated within ninety (90) calendar days; therefore the individual will be disenrolled, but will remain in pending status for ninety (90) calendar days to allow for Medicaid Eligibility to be reinstated; therefore, retaining the slot. The Community Supports Waiver effective date of disenrollment will be the day before the individual became Medicaid ineligible.

    - **If Medicaid eligibility is not reinstated** within ninety (90) calendar days, the individual will be removed from pending status and the slot will be revoked.

    - **If Medicaid is reinstated** within ninety (90) calendar days the individual may be enrolled without reapplying for a waiver slot. You must notify the Waiver Enrollments Coordinator that the individual has regained Medicaid Eligibility and is ready to be enrolled. You will be responsible for completing a new Freedom of Choice form along with submitting a new initial request for Level of Care evaluation to the in Consumer Assessment Team along with updating the plan. The Waiver Enrollments Coordinator will complete the DHHS Form 118A and forward it to the SCDHHS Eligibility Worker.

2. **An individual has not received any service(s) for thirty (30) calendar days <u>due to provider non-availability or individual's injury/illness</u>.** The individual will be disenrolled, but will remain in pending status for ninety (90) calendar days to allow for provider procurement or individual's recuperation; therefore, retaining the slot. The Community Supports Waiver effective date of disenrollment will be forty (40) calendar days following the individual's last date of service or forty (40) calendar days from their enrollment date, if no services received. If the form is being completed late, the Community Supports Waiver effective date of disenrollment will be ten (10) calendar days from the date that the **Notice of Disenrollment (Community Supports Form 17)** is completed. [1] **If an individual has an illness or injury** that prevents them from receiving any Community Supports Waiver service for thirty (30) days, they must be disenrolled from the Community Supports Waiver with ten (10) calendar days notice, but they can remain in pending status for ninety (90) calendar days to allow for recuperation. For example, an individual is only receiving day supports through the Community Supports Waiver and he/she injures himself. The injury prevents him from attending the day program and receiving day supports and no other Community Supports Waiver services are needed. [2] **If a provider cannot be located** to meet an individual's need(s) and the individual has not received a service in thirty (30) calendar days, they must be disenrolled from the Community Supports Waiver with ten (10) calendar days notice, but they can remain in pending status for up to ninety (90) calendar days to locate a provider.

    - **If a provider has not been located or the individual is not ready to resume services** within ninety (90) calendar days, the individual will be removed from pending status and the slot will be revoked.

    - **If a provider is located or the individual is ready to resume services** within ninety (90) calendar days the individual may be enrolled without reapplying for a waiver slot. You must

notify the Waiver Enrollments Coordinator that the individual is ready to be re-enrolled. You will be responsible for completing a new Freedom of Choice form again along with submitting a new initial request for Level of Care evaluation to the Consumer Assessment Team. The Waiver Enrollments Coordinator will complete the DHHS Form 118A and forward it to the SCDHHS Eligibility Worker.

3. **An individual has entered the hospital/nursing facility/jail for an extended period of time that has exceeded thirty (30) calendar days**; however, the individual will still require their Community Supports Waiver services when released from the hospital/nursing facility/jail. Therefore, the individual will be disenrolled, but will remain in pending status for ninety (90) calendar days; thereby, retaining the slot. The Community Supports Waiver effective date of disenrollment will be thirty (30) calendar days following the individual's last date of service.

    - **If the individual has not been released from the hospital/nursing facility/jail** within ninety (90) calendar days, the individual will be removed from pending status and the slot will be revoked.

    - **If the individual is discharged from the hospital/nursing facility/jail** within ninety (90) calendar days then the individual may be enrolled without reapplying for a waiver slot. You must notify the Waiver Enrollments Coordinator that the individual is ready to be re-enrolled. You will be responsible for completing a new Freedom of Choice form along with submitting a new initial request for Level of Care evaluation to the Consumer Assessment Team. The Waiver Enrollments Coordinator will complete the DHHS Form 118A and forward it to the SCDHHS Eligibility Worker.

The following special exception allows an individual to disenroll from the Waiver, but retain their Waiver slot until the next funded year:

The individual has reached the individual cost limit. If the individual has reached the Community Supports Waiver individual cost limit, no further services will be provided. The waiver slot will be put into "pending" status and the individual will be disenrolled. The disenrollment effective date will be the last day services were rendered. You will complete a **Notice of Disenrollment (Community Supports Form 17)** and forward a copy to the Waiver Enrollments Coordinator.

If the **Notice of Disenrollment (Community Supports Form 17)** is not completed in 2 business days and forwarded to the Waiver Enrollments Coordinator, the provider **could be** responsible for payment of state plan or direct billed services. If the **Notice of Disenrollment (Community Supports Form 17)** is completed more than 2 business days after the disenrollment date, you must include the reason for delay. Often times the reason may be very legitimate (i.e. individual dies and family does not contact you immediately); however, it **MUST** be noted on the **Notice of Disenrollment (Community Supports Form 17).** SCDHHS requires this information from SCDDSN. If it is not included, you will be contacted for this information and disenrollment will be delayed.

Regardless of the reason for disenrollment, it is the responsibility of the Service Coordination Supervisor or Early Intervention Supervisor to check the Waiver Tracking System to ensure that the individual has indeed been disenrolled within two days of submission of the **Notice of Disenrollment (Community Supports Form 17)**. When checking the WTS, you will note that the termination/disenrollment date will be directly under "Enrollment End Date" although there is an "E" in the Enrollment Status column. If you find after checking the system on several occasions that the individual continues to be enrolled, contact the Waiver Enrollments Coordinator immediately (see Attachment 2, Chapter 7) to ensure that the **Notice of Disenrollment (Community Supports Form 17)** was received.

Please Note: If for some reason an enrollee is determined not to have Mental Retardation or Related Disability, you must complete a Level of Care Re-Evaluation which is warranted anytime an individual's condition changes. Since the individual is no longer eligible for DDSN services (meaning the individual does not have a diagnosis of Mental Retardation or Related Disability), the individual would not meet ICF/MR Level of Care since ICF/MR Level of Care requires a diagnosis of Mental Retardation or Related Disability. Therefore, you must submit the adverse Level of Care to the Consumer Assessment Team as outlined in Chapter 5. **You cannot disenroll an individual from the Community Supports Waiver solely based on an eligibility decision.** A Level of Care Re-evaluation must be done and this decision upheld by the Consumer Assessment Team before the individual can be disenrolled. Once this is received, you can proceed with disenrollment according to the outlined policy.

Please note: If an individual has been disenrolled due to no service in thirty (30) calendar days and within the ten (10) calendar day notice timeframe services can be reinstated, then the disenrollment can be disregarded. In order to do this you must contact the Waiver Enrollments Coordinator (prior to the disenrollment effective date) to request that the disenrollment be voided. Furthermore, you must contact Donna M. Johnson at 803-898-9782 or Trina Smalley at 803-898-9630 in the Cost Analysis Division at DDSN Central Office to have the budget reinstated.

South Carolina Department of Disabilities and Special Needs
Community Supports Waiver
Notice of Disenrollment

Date Form Completed: _____

Individual's Name: _____
Medicaid #: | | | | | | | | | | |

SSN#: | | | | | | | | | |

The person named above is no longer eligible to receive services funded through the Community Supports Waiver for the reason noted below:

☐ Death	☐ Admitted to an ICF/MR	☐ No longer meets ICF/MR LOC
☐ No longer eligible for Medicaid	☐ Admitted to Nursing Facility	☐ Individual moved out of state
☐ No service since enrollment	☐ Voluntary withdrawal	☐ No services in 30 consecutive days
☐ Moving to MR/RD Waiver	☐ Other _____	

☐ ***Medicaid eligibility has been interrupted, but should be reinstated within 90 days*** *[The individual will be disenrolled, but will remain pending for 90 days; therefore, retaining the waiver slot. If a Medicaid is not reinstated within 90 days, the individual will be removed from pending status and the slot will be revoked. If Medicaid is reinstated, the individual may be reenrolled;[Freedom of Choice must be completed and a new initial Level of Care requested]*.

☐ **Individual has not received a service for 30 consecutive calendar days <u>due to provider non-availability or individual's injury/illness</u>** [The individual will be disenrolled, but will remain pending for 90 days; therefore, retaining the waiver slot. If a provider has not been located or the individual is not ready to resume services within 90 days, the individual will be removed from pending status and the slot will be revoked. If a provider is secured or the individual is ready to resume services within 90 days, the individual may be re-enrolled; [Freedom of Choice must be completed and a new initial Level of Care requested]. List the service(s) needed, but not received:_____.

☐ ***Individual has entered the <u>hospital/nursing facility/jail</u> (please circle appropriate facility)*** *that has exceeded 30 consecutive calendar days; however, the individual will require Community Supports Waiver Services when released from the hospital/nursing facility/jail the individual will be disenrolled, but will remain pending for 90 days; therefore, retaining the waiver slot. If the individual has not been released from the hospital/nursing facility/jail within 90 days, the individual will be removed from pending status and the slot will be revoked. If the individual is released from the hospital/nursing facility/jail within 90 days, the individual may be re-enrolled; [Freedom of Choice must be completed and a new initial Level of Care requested]*.

☐ **Individuals has reached individual cost limit.** Individual will be disenrolled and the slot will go into "pending" status

EFFECTIVE DATE OF DISENROLLMENT: _____/_____/_____

The effective date is 10 calendar days from the date the form is completed with the exception of death, loss of Medicaid, hospital/nursing facility/jail stay exceeded 30 calendar days, admission to an ICF/MR or Nursing Facility, moves out of state, or moves to MR/RD Waiver. This allows the individual/legal guardian notice prior to disenrollment/loss of services and the right to appeal without services being terminated.

As a result of this disenrollment, service(s) currently being provided will be terminated with this effective date. Contact your Service Coordinator/Early Interventionist about these services or any questions that you may have.

If form completed more than 2 business days after the disenrollment date, provide reason for delay:_____

Service Coordinator/Early Interventionist:_____E-Mail Address_____

DSN Board/Provider:_____ Phone:_____

Address:_____

Signature: _____ Date: _____/_____/_____

Service Coordination/Early Intervention Supervisor's Signature:_____

Original: Individual/Legal Guardian Copy: Waiver Enrollments Coordinator, Regional DHHS Medicaid Eligibility Worker and File

SCDDSN RECONSIDERATION PROCESS AND SCDHHS MEDICAID APPEALS PROCESS

The SC Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Mental Retardation/Related Disability (MR/RD) Waiver, the Community Supports (CSW) Waiver, the Head and Spinal Cord Injury (HASCI) Waiver and the Pervasive Development Disorder (PDD) Waiver. A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the individual, representative, or person assisting the individual in filing the request. If necessary, staff will assist the individual in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the individual/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the individual/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the individual/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the individual/representative fully completes the above reconsideration process and is dissatisfied with the results, the individual/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The individual/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The individual/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the individual/representative must clearly state with specificity, which issue(s) the individual/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30^{th}) calendar day following receipt of the SCDDSN written reconsideration decision. The individual/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

South Carolina Department of Disabilities and Special Needs
Community Supports Waiver
Voluntary Termination Statement

Please Type or Print

Individuals Name:_____

Social Security Number: ___1 ___2 ___3 - ___4 ___5 - ___6 ___7 ___8 ___9

I, _____, as individual or legal guardian, request that the above named individual be terminated from the Community Supports Home and Community Based Waiver.

I understand that the services noted below, which are currently being provided to the individual and are funded through the Community Supports will no longer be funded in that manner.

EFFECTIVE: _____/_____/_____.

- ☐ Respite Services
- ☐ Adult Day Health Care
- ☐ Assistive Technology
- ☐ Day Activity
- ☐ Employment Services
- ☐ Career Preparation
- ☐ Community Services
- ☐ Support Center Services
- ☐ Personal Care Services
- ☐ Psychological Services
- ☐ In-Home Support Services
- ☐ Adult Day Health Care-Nursing
- ☐ Adult Day Health Care-Transportation
- ☐ Private Vehicle Modifications
- ☐ Environmental Modifications
- ☐ Behavior Support Services

I understand that termination from the Community Supports Waiver may affect the individual's eligibility for Medicaid.

I understand that termination from the Community Supports Wavier does not affect the individual's eligibility for available services from the South Carolina Department of Disabilities and Special Needs (SCDDSN) and that voluntary termination does not prohibit future participation in the Community Supports Waiver should the individual choose to re-apply for the program.

_____ _____

Individual's Signature | Legal Guardian / Family Member Signature

_____

Service Coordinator/Early Interventionist

Original: File Copy: Individual/Legal Guardian and Lead Coordinator for Community Supports Waiver and Service Planning